

# **EFFECTIVE 3/30/2014**

## **28 Texas Administrative Code**

### **Chapter 133 - GENERAL MEDICAL PROVISIONS**

#### **CHAPTER 133: GENERAL MEDICAL PROVISIONS**

##### **SUBCHAPTER A: GENERAL RULES FOR MEDICAL BILLING AND PROCESSING**

**AMEND: §133.2**

##### **SUBCHAPTER C: MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER**

**AMEND: §133.240 AND §133.250**

##### **SUBCHAPTER D: DISPUTE OF MEDICAL BILLS**

**AMEND: §133.305**

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#### **Subchapter A - GENERAL RULES FOR MEDICAL BILLING AND PROCESSING**

##### **§133.2. Definitions.**

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

- (1) Adverse determination--A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An adverse determination does not include a determination that health care services are experimental or investigational.
- (2) Agent--A person whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligations under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to "agent" as used in the term "pharmacy processing agent."
- (3) Bill review--Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, division or department rules, and the appropriate fee and treatment guidelines.

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(4) Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(5) Emergency--Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(6) Final action on a medical bill--

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(7) Pharmacy processing agent--A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the utilization review agent during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(9) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

[This provision will become effective 3/30/2014.](#)

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## Subchapter C - MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER

### §133.240. *Medical Payments and Denials.*

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments). For pharmaceutical services provided to any injured employee, the insurance carrier shall not deny reimbursement based on medical necessity for pharmaceutical services preauthorized or agreed to under Chapter 134, Subchapter F of this title (relating to Pharmaceutical Benefits).

(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

(d) The insurance carrier may request additional documentation, in accordance with §133.210 of this title (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

(e) The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and

(2) the injured employee when payment is denied because:

(A) of an adverse determination;

(B) the health care was provided by a health care provider other than:

(i) the treating doctor selected in accordance with Labor Code §408.022;

(ii) a health care provider that the treating doctor has chosen as a consulting or referral health care provider;

(iii) a doctor performing a required medical examination in accordance with §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Required Medical Examination);

(iv) a doctor performing a designated doctor examination in accordance with Labor Code §408.0041; or

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(C) the health care was unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(3) the prescribing doctor, if different from the health care provider identified in paragraph (1) of this subsection, when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services.

(f) The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

- (1) division claim number, if known;
- (2) insurance carrier claim number;
- (3) injured employee's name;
- (4) last four digits of injured employee's social security number;
- (5) date of injury;
- (6) health care provider's name and address;
- (7) health care provider's federal tax ID or national provider identifier if the health care provider's federal tax ID is the same as the health care provider's social security number;
- (8) patient control number if included on the submitted medical bill;
- (9) insurance carrier's name and address;
- (10) insurance carrier control number;
- (11) date of bill review/refund request;
- (12) diagnosis code(s);
- (13) name and address of company performing bill review;
- (14) name and telephone number of bill review contact;
- (15) workers' compensation health care network name (if applicable);
- (16) pharmacy, durable medical equipment, or home health care services informal or voluntary network name (if applicable) pursuant to Labor Code §408.0281 and §408.0284;
- (17) health care service information for each billed health care service, to include:
  - (A) date of service;
  - (B) the CPT, HCPCS, NDC, or other applicable product or service code;

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(C) CPT, HCPCS, NDC, or other applicable product or service code description;

(D) amount charged;

(E) unit(s) of service;

(F) amount paid;

(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

(18) a statement that contains the following text: "Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of the liability under Labor Code §408.024. However, pursuant to §133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination";

(19) if the insurance carrier is requesting a refund, the refund amount being requested and an explanation of why the refund is being requested; and

(20) if the insurance carrier is paying interest in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds), the interest amount paid through use of an unspecified product or service code and the number of days on which interest was calculated by using a unit per day.

(g) When the insurance carrier pays a health care provider for health care for which the division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline).

(h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

(1) the injury is not compensable;

(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the health care was provided was not related to the compensable injury.

(i) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title.

(j) If the health care provider is requesting reconsideration of an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations). If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

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(k) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D of this title.

(l) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.130 of this title without any action taken by the division. The interest payment shall be paid at the same time as the medical bill payment.

(m) Except as provided by Insurance Code §1305.153, when an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the full amount that the insurance carrier reimburses. If the insurance carrier remits payment under Insurance Code §1305.153, then the payment must be made in accordance with that section.

(n) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy processing agent's reimbursement from the insurance carrier shall be made in accordance with §134.503 of this title. The pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(o) An insurance carrier commits an administrative violation if the insurance carrier fails to pay, reduce, deny, or notify the health care provider of the intent to audit a medical bill in accordance with Labor Code §408.027 and division rules.

(p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

[This provision will become effective 3/30/2014.](#)

### **§133.250. *Reconsideration for Payment of Medical Bills.***

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of

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service.

(c) A health care provider shall not submit a request for reconsideration until:

- (1) the insurance carrier has taken final action on a medical bill; or
- (2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

(d) A written request for reconsideration shall:

- (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;
- (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;
- (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and
- (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

(e) An oral request for reconsideration must clearly identify the health care service(s) denied based on an adverse determination and include a substantive explanation in accordance with §133.3 of this title that provides a rational basis to modify the previous denial or payment. Not later than the fifth working day after the date of receipt of the request for reconsideration, the insurance carrier must send to the requesting party a letter acknowledging the date of the receipt of the oral request that includes a reasonable list of documents the requesting party is required to submit. This subsection applies to reconsideration requests made on or after six months from the effective date of this rule.

(f) An insurance carrier shall review all written reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete written reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its written request to the insurance carrier.

(g) The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:

- (1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or
- (2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

(h) A health care provider shall not resubmit a request for reconsideration earlier than 35 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request.

(i) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions

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of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(j) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(k) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Adverse Determination) and §19.2011 of this title, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

[This provision will become effective 3/30/2014.](#)

## Subchapter D - DISPUTE OF MEDICAL BILLS

### §133.305. MDR--General.

(a) Definitions. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) First responder--As defined in Labor Code §504.055(a).

(2) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code §4201.002.

(3) Medical dispute resolution (MDR)--A process for resolution of one or more of the following disputes:

(A) a medical fee dispute; or

(B) a medical necessity dispute, which may be:

(i) a preauthorization or concurrent medical necessity dispute; or

(ii) a retrospective medical necessity dispute.

(4) Medical fee dispute--A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes). The following types of disputes can be a medical fee dispute:

(A) a health care provider, or a qualified pharmacy processing agent as described in Labor Code §413.0111, dispute of an insurance carrier reduction or denial of a medical bill;

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(B) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and

(C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

(5) Network health care--Health care delivered or arranged by a certified workers' compensation health care network, including authorized out-of-network care, as defined in Insurance Code Chapter 1305 and related rules.

(6) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. "Non-network health care" includes health care delivered pursuant to Labor Code §408.0281 and §408.0284.

(7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent utilization review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this title (relating to MDR of Medical Necessity Disputes).

(8) Requestor--The party that timely files a request for medical dispute resolution with the division; the party seeking relief in medical dispute resolution.

(9) Respondent--The party against whom relief is sought.

(10) Retrospective medical necessity dispute--A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this title.

(11) Serious bodily injury--As defined by §1.07, Penal Code.

(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

(c) Division Administrative Fee. The division may assess a fee, as published on the division's website, in accordance with Labor Code §413.020 when resolving disputes pursuant to §133.307 and §133.308 of this title if the decision indicates the following:

(1) the health care provider billed an amount in conflict with division rules, including billing rules, fee guidelines or treatment guidelines;

(2) the insurance carrier denied or reduced payment in conflict with division rules, including reimbursement or audit rules, fee guidelines or treatment guidelines;

(3) the insurance carrier has reduced the payment based on a contracted discount rate with the health care provider but has not made the contract or the health care provider notice required under Labor Code §408.0281 available upon the division's request;

(4) the insurance carrier has reduced or denied payment based on a contract that indicates the direction or

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management of health care through a health care provider arrangement that has not been certified as a workers' compensation network, in accordance with Insurance Code Chapter 1305 or through a health care provider arrangement authorized under Labor Code §504.053(b)(2); or

(5) the insurance carrier or healthcare provider did not comply with a provision of the Insurance Code, Labor Code or related rules.

(d) Confidentiality. Any documentation exchanged by the parties during MDR that contains information regarding a patient other than the injured employee for that claim must be redacted by the party submitting the documentation to remove any information that identifies that patient.

(e) Severability. If a court of competent jurisdiction holds that any provision of §§133.305, 133.307, or 133.308 of this title is inconsistent with any statutes of this state, unconstitutional, or invalid for any reason, the remaining provisions of these sections remain in full effect.

*This provision will become effective 3/30/2014.*

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